Supreme Court, U.S.
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No. 04 355

IN THE

SUPREME COURT OF THE UNITED STATES

EMERSON M.F., JOU, M.D.

PETITIONER

vs.

FIRST INSURANCE COMPANY OF HAWAII, LTD.,

RESPONDENTS

On Petition For A Writ Of Certiorari To The Supreme Court Of The State of Hawaii

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

I. Whether a state agency's decision against Petitioner and in favor of an insurance company deprived Petitioner of his right to a fair hearing before an unbiased tribunal because one of the members of the agency's advisory panel, appointed to review the complaint against Petitioner, was paid-off by the insurance company?

II. Whether the state committed a regulatory taking by requiring extra-statutory licensing of physicians or their employees; and, whether the regulatory taking was *ad hoc* rule making without due process of law?

III. Whether singling out a board certified physiatrist for treatment disparate from other physicians who employ others incident to their services violates the equal protection clause?

IV. Whether the state judiciary violated Petitioner's Constitutional Rights to Due Process of law under the Fifth And Fourteenth Amendment?

PARTES TO THE PROCEEDING

All parties appear in the caption of this case, on the cover page. The Special Compensation Fund is not a party to this proceeding.

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OPINIONS BELOW

Petitioner respectfully prays that a writ of certiorari issue to review the decisions below:

The Order Denying Application For Writ Of Certiorari, by the Supreme Court of The State Of Hawaii appears at Appendix "A" to this Petition and is unpublished.

The Summary Disposition Order of the Hawaii Intermediate Court of Appeals, appears at Appendix "B" to this Petition, and is unpublished.

The decision of the Labor And Industrial Relations Appeals Board, State of Hawaii appears at Appendix "C" to this Petition.

JURISDICTION

The date on which the Supreme Court of The State of Hawaii denied certiorari in this case was June 10, 2004. Appen "A". No petition for rehearing was filed.

The jurisdiction of this Court is invoked under 28 §1257(a), or Rule 10(b) of the Supreme Court Rules.

CONSTITUTIONAL PROVISIONS INVOLVED

UNITED STATES CONSTITUTION

Amendment V [1791]

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand

Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

[ARTICLE XIV. - 1868]

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any Sate deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Other Provisions Appended Hereto

A. Medicare B. News
B. Code Of Federal Regulations 42 CFR 410.60
C. Medicare Fee Schedule, And Other Excerpts Of The State of Hawaii. Title 12, Hawaii Administrative Rules
D. Hawaii Revised Statutes, Sections §386-27, §452-1, §453-1 and §461J-1

STATEMENT OF THE CASE

Petitioner, Emerson M.F. Jou, M.D. is a physician in private practice in Honolulu, Hawaii. He is board certified in physiatry. Schneiden v. Chavez-Munoz, 9 Neb.App.579, 586, 616 N.W.2d 46, 53 (App. 2000); Bocalbos v. Kapiolani Med. Ctr., 93 Haw. 116, 119 fn.12, 997 P.2d 42, 45 (App. 2000).

Respondent First Insurance Company of Hawaii Ltd (FICOH) is an insurance company selling worker's compensation, automobile and other property and casualty (P&C) insurance. In 2002, Hawaii P&C insurer's premiums, other than for life and annuity policies, totaled $1,796,690,502.00, while their claims benefits were only $708,842,399.00. Report of The Insurance Commissioner of Hawaii 2003 ("Cmr. Rpt") at 45. FICOH's 2002 Hawaii premiums were $72,328,085.00 against claims benefits paid of only $25,057,890.00. Id at 19.

The nearly 1.8 billion in premium charged by these insurers for insurance which includes health coverage overlaps with another $2.1 billion Hawaii residents paid to their HMOs and mutual benefit societies for health insurance. Id at 47. Added to this $3.9 billion burden on +1.2 million Hawaii residents, is another ±1.5 billion for life insurance and annuity premiums.

The Special Compensation Fund (SPF) took no part in the appeals below to the ICA or Hawaii Supreme Court.

Between August 31, 1987, and July 27, 1990, Petitioner provided services to an injured worker within

the scope of his board certification in physiatry. Appendix ("Appn") C.4 ¶ nos. 1-2.

On March 5, 1990, Respondent FICOH filed a complaint against Petitioner in the State Department of Labor And Industrial Relations (Appn. C.4) wherein was raised the propriety of Petitioner, Dr. Jou's billing reports, use of non-specific measures, prolonging passive therapy, and not referring the injured worker to a psychiatrist. Appn. C.4 ¶ no. 7, 8. To obtain a recommended disposition the state appointed an advisory panel of doctors. Members of this panel receive statutory immunity. They are to be paid by the state. Panelists were required to review the complaint, filed by Respondent before recommending a disposition of the case to the director of labor.

This appointment was over objection made by Petitioner's then counsel to the labor department. RA (record on appeal below) 218, 219. This objection was for bias and prejudgment (RA 218) and, most significantly the federal question of bias for pecuniary interest was raised. The panelist had already been paid handsomely for other work done avoiding Petitioner's medical benefit claim for an injured worker: "We could not get a fair hearing from him. He is already bought and paid for by one of the parties." RA 218. Emphasis added.

On July 20, 1990, after appointing the panel, the members, including FICOH's panelist, recommended that Petitioner be reprimanded. Appn. C.5, ¶ no. 9.

On August 21, 1990 Respondent insurer amended its complaint to challenge Petitioner's use of licensed massage therapists to perform modalities within the scope of licensure of physicians and LMTs in the state. These

procedures were incident to Petitioner's services as a physician, specializing in physiatry.

On November 21, 1990 the state labor director found for the insurance company (Respondent) and, inter alia imposed a $7,000.00 fine on Petitioner. Emerson M.F. Jou, M.D., appealed this decision to the Hawaii Labor And Industrial Relations Appeals Board (LIRAB).

On April 2, 1991 the LIRAB remanded the case back to the director to compute amounts which the LIRAB predetermined to be paid for modalities which were limited to licensed physical therapists and not physiatrists (M.D.'s), incident to their services. Appn C.7 no. 13.

On October 4, 1991, Petitioner's then counsel objected to the use of the bill coding service (AccuMed's report). Appn. C.8 no. 17. The director passed on the objection by admitting the report.

The AccuMed report was admitted against Petitioner, over objection, because the hearing officer decided "it is the basis for their request to have the amounts paid to Dr. Jou reimbursed." RA 858 (Exhibit Q to Respondent's First Supplement To Exhibit List).

On October 30, 1991 the state labor director made a supplemental decision against Petitioner, agreeing with the insurance company and ordering reimbursement. Appn. C.9 no. 18. Petitioner timely appealed. Id.

On August 8, 2001 the appeal was heard before the LIRAB (RA 1170). Therein, and by a post trial brief, Petitioner preserved federal questions: (1) "structural due process" violation, by using a paid-off state appointed

panelist to penalize Petitioner, RA 1173, (2) procedural due process violation by "pecuniary interest in the outcome" by a decision maker, RA 1173, (3) procedural due process violation by blocking cross examination and access to witnesses in agency, and on de-novo review, of billing evaluator (downcoder) to arbitrarily recode the billings based on the state's erroneous assumption that the billing done for Petitioner's services was outside the scope of his practice, and somehow not incident to his services as a physiatrist. RA 1175-1180 ("due process right to cross examine and confront witness" [RA 1176]).

The way in which these federal questions were passed on by the Hawaii Labor and Industrial Relations Appeals Board was by written Decision and Order filed on December 17, 2001, Appn. C. Curiously, the LIRAB thought that the panelist did not address Petitioner's reporting procedures, but conceded that Dr. Kam's opinion concluded that Dr. Jou prolonged physical therapy treatments and violated the law "by not following reporting requirements". Appn C. 6.

The LIRAB passed on the federal questions raised by Dr. Kam's pecuniary interest, almost in passing (Appn. C. 17 ¶ no. 3):

> "3. Pursuant to HRS §386-27(d) and §12-13-20, the Director has the discretion to convene an advisory panel if he determines that one is necessary. Our review of the record shows that the panel was convened in accordance with the statute and related administrative rules. Claimant has presented no evidence to show that the panel was improperly convened. Claimant's objection to

> First Insurance's choice of panelist is not a legal ground to bar the Director from convening an advisory panel." Appn. C.17.

The LIRAB passed on the federal questions raised by Petitioner over the misuse of AccuMed to down code his services, in cursory fashion.

> "36. Contrary to Dr. Jou's assertions, the Director's calculations in the October 30, 1991 supplemental decision were not based on the AccuMed report submitted by First Insurance. The Director's calculation of the amount of reimbursement differed from the AccuMed calculation.
>
> 37. Based on our review of the record, we find that the Director properly disallowed billings for treatments that were performed by individuals who were not licensed physical therapists".

On December 27, 2001 Petitioner timely appealed to the Hawaii appellate courts for review of the decision after trial de novo by the LIRAB. RA 1255-1276. On February 4, 2002 Petitioner filed a Request to Prepare Transcript on Appeal. RA 338. That transcript has yet to be filed by the Appeals Board clerk.

Nearly 3.5 years after noticing the appeal the Intermediate Court of Appeals, State of Hawaii (ICA) rendered its decision. Appn. B. The federal questions sought to be reviewed on certiorari to this Court were raised by the briefs on the merits. The federal questions

were passed on by the ICA in its unpublished summary disposition order filed May 7, 2004. Appn. B.

First, Petitioner, raised to the appellate court, the well preserved federal questions involved with the state's appointed panelists having been paid from two sources: the state fund; and, prior thereto by the insurance company, Respondent. The question was fully argued in Petitioner's brief on the merits ("Op. Br") 2, 18-25:

> ". . . a medical advisory board member who had been paid by the Appellee insurer to render an opinion against the Appellant prior to being accepted on the state panel is no different than a jurist with a financial interest in fines collected by his court . . . a due process violation even through the financial interest by Dr. Kam may be relatively small". Op. Br. 22. [Petitioner there cited the court to the Fifth and Fourteenth Amendment. Op. Br. 2].

The ICA passed on this federal question by saying "Dr. Kam was paid by the special compensation fund the same amount ($200) as the other panel members . . . " (Appn. B.6 ¶1) and "the advisory panel was just that, advisory". Id.

Second, Petitioner raised the federal question to the ICA of a regulatory taking, under the Fifth Amendment. His challenge earlier, in the LIRAB, clearly raised this question when that board upheld a coding scheme paying physicians less than physical therapists for the same services. Op. Br. 8: ("Dr. Jou believed that it was wrong to compensate a physical therapist more than a physician." Appn. C. ¶ No. 26. In his opening brief at 14 Petitioner informed:

"Taking's Clause Violation

The use by the Hawaii department of Labor of an administrative rule in conflict with the Hawaii Revised statutes, effected a taking of Dr. Jou's property without due process of law". This issue was raised below at R 1171.

The ICA passed on this question by saying (Appn B.7 ¶2): "Dr. Jou makes no detectable argument in support of this assertion, and thus fails in his burden on appeal to prove the administrative provisions unconstitutional . . . " Id.

Third, Petitioner raised the federal question that his right to equal protection under the Fourteenth Amendment had been violated when the state allowed the insurer's IME neurosurgeon (Kam) on its panel to challenge Petitioner's treatments. Op. Br. 2. The ICA did not pass on this question.

On June 1, 2004, Petitioner filed for discretionary review in the Hawaii Supreme Court. He raised federal questions therein which were not passed upon by that Court because it denied review. Appn. A. The federal questions raised were:

"A. Whether the State's conduct, approved by the ICA, penalizing the physician's practice and requiring additional licensure as a physical therapist is a regulatory taking, violating the Fifth Amendment And Fourteenth Amendments to The United States Constitution, and Article I Sections 4 and 5 of the Hawaii Constitution? Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 414, 43 S.Ct 158 (1922); Aged Hawaiians v. HHC, 78 Haw. 192, 203, 891 P.2d 279 (1995).

B. Whether the ICA authorized the State, by its agency (LAB), to deprive Petitioner property without due process of law by permitting the use of a review board panelist who received payment prior to the proceedings for an IME on the same case? Beauchamp v. De Abadia, 779 F.2d 773, 775 (1st Cir. 1985).

. . . . . .

. . . . . .

E. Whether the ICA-approved conduct by the agency limiting the physician's scope of practice, and limiting the use of employees and products incident to the physician's services, constituted rule-making without due process, in violation of the 14th Amendment to The United States Constitution, and Article I Sections 4 and 5 of the Hawaii State Constitution?

F. Whether the ICA's endorsement of the agency's conduct restricting the property rights of Petitioner violated Petitioner's rights to equal protection under the Fourteenth Amendment to The United States Constitution? Shelley v. Kraemer, 334 U.S. 1, 17, 68 S.Ct. 836 (1948); and whether the ICA's decision singled Petitioner out for treatment disparate from other physicians who employ licensed non physicians incident to their services?"

ARGUMENT

I. THE STATE'S APPOINTMENT OF A MEDICAL PANELIST WHO HAD PREVIOUSLY BEEN PAID BY THE PARTY INSTITUTING THE ACTION DEPRIVED PETITIONER OF DUE PROCESS OF LAW UNDER THE FIFTH AND FOURTEENTH AMENDMENTS

A. Background

After Respondent filed a complaint against Petitioner Emerson M.F. Jou, M.D., state agency rules allowed it to submit one proposed panelist to the director, together with two alternates. HAR §12-13-20(a). See page 4, supra.

Respondent's complaint against Dr. Jou centered on whether he was required to hire licensed physical therapists in his physical medicine and rehabilitation clinic. If so, the Respondent would have to pay very little for services already provided to individuals insured by Respondent.

Petitioner Jou's position remains that an administrative agency rule limiting services to licensed physical therapists could only rationally apply to LPTs in their own practice. This is consistent with the state's scope of licensure laws for physicians, as well as persuasive authorities which have dealt with LPTs in private practice. Downtown Medical Center v. Bowen, 944 F.2d 756, 765-769 (10th Cir. 1991).

Respondent insurance company has sought, and obtained, the state's assistance in avoiding payment for benefit claims for medical services rendered; and, for its part, the state of Hawaii through administrative and judicial action, has left its "clear and unmistakable imprimatur" on conduct depriving Petitioner of the right to work in the State of Hawaii. Truax v. Raich, 239 U.S. 33, 41, 36 S.Ct. 7 (1915); Shelley v. Kraemer, 334 U.S. 1, 18, 68 S.Ct. 836 (1948).

To help railroad Dr. Jou out of practice, the state's labor director convened a tribunal (including an "advisory" panel), which, through its corrupt practices infected the entire proceeding as it moved through the state agency, and the state appellate courts.

By statute, the panelist's fees "shall be paid for by the special compensation fund." HRS §386-27(d). Emphasis added. The amount was fixed by administrative rule at $200. HAR §386-27(d). Emphasis added.

Once appointed by the state labor director, members of the advisory panel were cloaked with judicial or quasi judicial immunity. HRS §386-27(d). The panel had subpoena powers. HAR §12-13-21(a). The advisory panel was specifically charged with reviewing the Respondent's complaint, with both the director and the Petitioner. HAR §§12-13-20(e); 12-13-21(a).

Further, the rules mandated that the advisory panel make a recommended disposition to the director of labor (HAR §12-13-21(a)); and that the recommended disposition be reviewed by the director before he holds a hearing. HAR §12-13-21(d).

The financially interested panelist, Dr. Kam, reviewed Respondent's complaint against Dr. Jou and incorporated thereto his own 33 page medical report which he had been paid previously by Respondent, to compile. RA 218, 219; 1171-1173, Op. Br. 19. But see Justice Lim's omission. Appn. B.6.

While the statute authorizing advisory panels required *sua sponte* recusal, Dr. Kam made no effort to raise thereunder any issue relating to his rewarding working

relationship with Respondent insurer. HRS §386-27(c). The insurer, the agency, and at least three state appellate justices thought Dr. Kam's retention as an arm of the director was just fine. Appn. B.

B. Dr. Kam's Presence On The Panel Was a Structural Due Process Violation

This Court has recognized that errors regarding the legitimacy of judges and jurors are structural. Tumey v. Ohio, 273 U.S. 510, 513, 47 S.Ct. 437 (1927); Bateson v. Kentucky, 476 U.S. 79, 85-87, 100, 106 S.Ct. 1712 (1986) (unlawful exclusion of jurors); Vasquez v. Hillary, 474 U.S. 254, 263-64 106 S.Ct. 617 (1986) (unlawful exclusion of grand jurors).

When error, as here is structural, prejudice below need not be proved. United States v. Cotton, 535 U.S. 625, 631, 122 S.Ct. 1781 (2002); Johnson v. United States, 520 U.S. 461, 468-69, 117 S.Ct. 1544 (1997).

Using a medical panelist with a pecuniary interest in the case to recommend a disposition and review Respondent's complaint infected the entire proceedings and the framework in which the trials proceeded. The practice "seriously affects the fairness, integrity or public reputation of judicial proceedings." Cotton at 631.

C. Dr. Kam's Presence Violated The Procedural Due Process Right To An Impartial Tribunal

Submitting disputes to a panel of three doctors who were mandated to make a recommended decision, violated the Due Process clause because of one of the panelists

(Kam's) pecuniary self interest. Gibson v. Berryhill, 411 U.S. 564, 578-79, S.Ct (1973).

The focus of this Court has not been limited to the judge's actions, but to the actions of the tribunal. In Re Murchision, 349 U.S. 133, 75 S.Ct. 623 (1955). There, a trial judge first convened a "one man judge-grand jury" and then tried and convicted two witnesses of contempt.

In reversing the Michigan Supreme Court, this Court found a due process violation when the trial judge who was part of the accusatory process thereafter conducted the trial. Likewise, at Bench, Petitioner was entitled to a fair tribunal, free of disqualifying bias, prior to final adjudication. "A trial before a tribunal financially interested in the result of its decision is a denial of due process of law." Tumey, supra 273 U.S. at 535. Emphasis added.

A fair tribunal has never been conceptually limited to judges. "A showing that administrative adjudicators were biased would establish a failing of procedural due process . . ." Green v. Amesqua, 212 F.3d 358, 368 (7th Cir. 2000); Connally v. Georgia, 429 U.S. 245, 251, 97 S.Ct. 546 (1977) (paying magistrates a $5 fee for granting a search warrant, but nothing for denying warrant applications, violates due process".

The standard is whether a "government official stands to profit economically." Marshall v. Jerrico, Inc., 446 U.S. 238, 242, 243, 247, 100 S.Ct. 1610 (1980). Unlike the Marshall facts (247) the tainted panel member at Bench reviewed the complaint (III A, supra), against Petitioner and made a written, recommended disposition on disputed factual questions. Id. The function of the panelist here was

not, as in Marshall, "that of a prosecutor or civil plaintiff." Id. Respondent insurer well occupied that position.

Even if the state's appointed panel was, as Justice Lim concluded "just that, advisory" (Appn. B.6), the venality of one of its members was imputed to a state adjudicator. Unlike partisan experts, the advisory panel members at Bench were subject to the control of the adjudicator, a state official. Like special masters, the panel members are held to the same standards as adjudicators. Jenkins v. Sterlacci, 270 U.S. App. D.C. 296, 849 F.2d 627, 632 (U.S. App. 1988).

"Adjudicator" is a term used in a broad sense by this Court to include the tribunal itself, in structural error analysis. Gray v. Mississippi, 481 U.S. 648, 668, 107 S.Ct. 2045 (1987) (judge and jury).

Like magistrates and special masters, the panel here was required to make recommended decisions to an adjudicator. Hawaii Administrative Rule ("HAR") 12-13-21; Jenkins, supra; Quillen v. Sec'y HHS, 793 F.2d 1293 (6th Cir. 1986).

A medical advisory panel member bought and paid for by Respondent insurance company had duties to recuse shared by adjudicators. The panelist, Dr. Kam was required sua sponte to determine if there was a conflict of interest. HAR §12-13-20 (C); U.S. v. Sartori, 560 F.Supp. 427, 431 (D.C. Md. 1983).

Since panel members also enjoyed, by statute, the cloak of a state adjudicator's absolute immunity (HRS §386-27(d)) the physicians on the state labor director's advisory panel were no different than court-appointed psychiatrists

in Hawaii to whom is extended the judicial brand of absolute immunity. The Hawaii Supreme Court has so held "to maintain the orderly administration of the judicial process". Seibel v. City and County of Honolulu, 63 Haw. 516, 522, 631 P.2d 173 (1981) ("reasons underlying judicial immunity, especially the freedom and independence to act without apprehension of possible adverse consequences apply equally to court appointed officials." Id at 523-525.

Thus, Justice Lim's rationale below, that panel members were not adjudicators and therefore not bound by the effects of financial interest rings hollow. As in Seibel, the panel members, as arms of the adjudicator, were bound by the same standards. Id at 525.

In upholding the state labor department's corrupt practice, the state courts trivialized the compensation limits set by the agency which were concerned with preventing both the possibility of bias and the appearance of bias. Syquia v. Board of Education, 80 N.Y.2d 531, 591 N.Y.S.2d 996, 606 N.E.2d 1387, 1390 (1992):

> "By prescribing equal compensation between the employee's designated panel member and the Boards designated member and by authorizing a system in which compensation would not be paid by either party, but rather from the Commissioners fund, the Legislature intended to eliminate even the appearance of financial influence." Emphasis added.

The state's answer to Syquia was to meticulously ignore the fact that Respondent insurance company had already hired, paid, and otherwise influenced its

designated panel member before the state paid him $200. Appn. B.6, ¶1.

By deliberately taking analytical steps to avoid confirming or denying the total overpayment to one of the panel members, the state courts were wrongly able to conclude that the insurer's panelist was paid the same as the others. Appn. B.6.

This odd approach avoided discussing the Respondent's panelist's (1) ongoing financial relationship in performing insurer IMEs (RA 118, 119) for Respondent (2) the panelist's financial gain in doing an IME and other work on the same case, before the state selected him and (3) his pecuniary interest in further business with Respondent insurer. It simply appears as if the Hawaii appellate court did not reach page 21 of the opening brief before it. It would have otherwise found Syquia (overpayment of member of tripartite panel by an institutional participant voids the result) and Carey v. Cvomo, 858 F.Supp.385, 387 (D.C. NY 1994). Op. Br. 21.

The state courts reached an unconstitutional end by erroneously comparing the labor department's medical advisory panel to privately retained experts or "hired quns." Appn. B.5. If this were true, then there would be no need for the $200.00 remuneration limits (HAR §12-13-22), and the ultimate use of experts would be determined by the litigants, and not by the director of labor. Hughes v. Long, 242 F.3d 121, 130 (3d Cir. 2001) (distinction between private versus court appointed experts).

Hawaii's indulgent and lowered expectations of, as the ICA put it, "party designated arbitrators" (Appn B.5) coupled with trivializing remuneration standards, does not

square with the use of appointed experts to avoid the "practice of shopping for experts, the venality of some experts, and the reluctance of many reputable experts to involve themselves in litigation." Notes of Advisory Committee on Rules, FRE 706.

II. ACTIONS BY HAWAII'S AGENCIES AND JUDICIARY VIOLATED THE FIFTH AND FOURTEENTH AMENDMENT

"The right to work for a living in the common occupations in the community is of the very essence of the personal freedom and opportunity that it was the purpose of the amendment to secure." Truax v. Raich, 239 U.S. 33, 41, 36 S.Ct. 7 (1915).

The decisions of the labor department (Appn. C) and the court (Appn. A, B) forces licensed physicians to employ physical therapists licensed in Hawaii as a condition to providing some of the medical services listed in the state's medical fee schedule. The state agency and a court rewrote the scope of practice of Hawaii physicians. This rule-making was "unreasonable governmental interference that comes within the 'liberty' and 'property' concepts of the Fifth Amendment". Greene v. McElroy, 360 U.S. 474, 492, 79 S.Ct. 1400 (1959).

The statutory scope of Appellant physician's practice, and his right to work in Hawaii, cannot be rewritten by agency actions on a medical fee schedule (MFS). The physician's scope of practice is broadly defined at HRS §453-1 ("Practice of medicine includes . . ."). Emphasis added.

Under HRS §453-1, even if physical therapy services were performed incident to Dr. Jou's services, those procedures were within the scope of a physician's license, rewritten by the state's action.

The MFS, which is incorporated into the state's administrative rules, unambiguously preserves the legislature's broad scope of licensure of doctors. HAR §12-13-31 (a): "All health care providers deemed qualified by the director may provide services to an injured employee. Treatment shall fall within the scope of the health care provider's license to practice." Emphasis added.

"Health care provider", a term defined by the MFS, was overlooked by the ICA. Here, the MFS incorporates HRS §382-1, which does not include licensed physical therapists or licensed massage therapists.

Therapeutic massage is unquestionably within a physician's scope of practice. The fight here is over whether state agencies and state courts may force physicians to hire licensed physical therapists instead of licensed massage therapists to perform services clearly and plainly within the state's statutory scope of licensure of physicians (HRS §453-1), and massage therapists. HRS §452.

Neither of these statutes can be rewritten or nullified by an agency or a court. To the extent the administrative fee schedule (MFS) (relied on by this Court) is inconsistent with the scope of licensure in the statutes, the MFS and judicial action thereon must constitutionally give way to the statutes. Agencies may not nullify statutes. P.U.C. (California) v. United Sates, 355 U.S. 534, 540, 78 S.Ct. 446 (1958); Oestereich v. Selective Service Board, 393 U.S. 233, 242, 89 S.Ct. 414 (1968) (Harlan, J., concurring).

III. THE STATE VIOLATED THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT BY LIMITING A PHYSICIAN'S SCOPE OF PRACTICE

While Petitioner's brief below (Op. Br. 2) raised the question of equal protection, the ICA's legislation from the Bench was an additional violation.

The ICA's unpublished resolution of this dispute (Appn. B) placed Dr. Jou apart from other doctors; and, in its one-on-one context, intentionally treated Dr. Jou differently from other doctors similarly situated. Since there is found in the opinion no rational basis for the difference in treatment, the state court committed a grave violation of the Fourteenth Amendment, to the U.S. Constitution. Village of Willowbrook v. Olech, 528 U.S. 562, 564, 120 S.Ct. 1073 (2000). Shelley v. Kraemer, 334 U.S. 1, 14, 68 S.Ct. 836 (1948).

IV. THE STATE VIOLATED THE FIFTH AND FOURTEENTH AMENDMENT OF THE UNITED STATES CONSTITUTION BY A REGULATORY TAKING UNDER PENNSYLVANIA COAL

The purpose of the state's action below was "not to protect the lives or safety of the public generally but merely to augment the property rights of a favored few." Pennsylvania Coal Co. v. Mahon, 260 U.S. 393, 396-398, 43 S.Ct. 158 (1922). Those favored few are the Hawaii judges who retain their jobs after deliberations of Hawaii's nine-member Judicial Selection Commission. Three of the JSC's members earn all or a substantial amount of income from the state health and property casualty insurers. These are:

JSC's chair Sidney K. Ayabe, Esq. (property casualty) and Rosemary Fazio, Esq. (health insurer, HMSA, $+1.2B premium, 2002). See Martindale-Hubbell Law Directory; also Cmr Rpt. 45, 47. The third member of the Hawaii Judicial Selection Commission is Lois Sazawa, a corporate vice president for a large property casualty insurer.

Packing Hawaii's Judicial Selection Commission with individuals whose major clients and employers have scores of cases pending before state judges, at any given, time is outrageous. At least one judge has spoken out on the outcomes:

> "In the absence of any publicly stated reasons for a judge's failure to be retained, remaining jurists are left to speculate, creating an uncertain environment that some say can affect judicial independence. Some judges may temper decisions to avoid controversy or delay controversial decisions until after their retention votes, according to some judges and lawyers.
>
> James Dannenberg a retired district judge, said he knows colleaques who delayed issuing controversial decisions for months until after their retentions were approved. In one case the delay was more than a year, Dannenberg said. He declined to provide the names of the colleagues involved.
>
> "I'm telling you the judges I speak to are very nervous about this (system), said Dannenberg, who still does per-diem work on the bench. 'It takes a very good judge to

decide, I am not going to be swayed by this.'"
Emphasis added.
starbulletin.com/2004/05/30/news/story

Others favored more richly, by Hawaii's limiting its physicians' scope of practice, are the Respondent (+72M Hawaii premiums versus +25M in claims benefits, /02), and its Hawaii property-casualty industry colleagues ($1.7 billion, '02 premium, exclusive of life and annuity policies versus only $+708M in claims benefits in Hawaii in '02). Cmr. Rpt 19, 45.

Pitted now against these principalities and powerful forces is a single doctor, and the Untied States Constitution.

Petitioner's property rights to practice his profession were also written into state law. HRS §453-1. The court below was required to follow the statute, not rewrite it. Likewise, the agency was not free to depart from its own rule, HAR §12-13-31: "Treatment shall fall within the scope of the health care provider's license to practice".

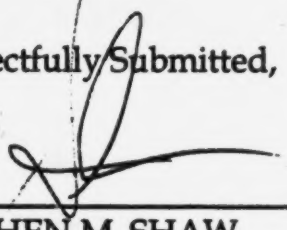
But for an unbridled, uncompensated common-law formulation by a state appellate court, Petitioner would be free to practice his profession as defined by the state's own rule of law. Shelley v. Kraemer, supra 334 U.S. at 17 n.19, 18.

CONCLUSION

This petition should be granted.

Dated: Honolulu, Hawaii, September 6, 2004.

Respectfully Submitted,



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FIRST INSURANCE COMPANY OF HAWAII, LTD.Respondent/Complainant-Appellee vs. EMERSON M.F. JOU, M.D., and EMERSON M.F.JOU, dba COMPREHENSIVE CLINIC OF REHABILITATION MEDICINE,Petitioner/Respondent-Appellant and SPECIAL COMPENSATION FUND, Respondent/Appellee NO. 24806

SUPREME COURT OF HAWAI'I

2004 Haw. LEXIS 442

June 10, 2004, Decided

PRIOR HISTORY: [*1] CERTIORARI TO THE INTERMEDIATE COURT OF APPEALS. CASE NO. MISC 90-001. *First Ins. Co. of Haw., LTD. v. Jou, 104 Haw. 322, 89 P.3d 535, 2004 Haw. App. LEXIS 144 (Haw. Ct. App., 2004)*

COUNSEL: Stephen M. Shaw for petitioner/respondent-appellant on the writ.

JUDGES: By: Duffy, J. for the court n1

n1 Considered by: Moon, C.J., Levinson, Nakayama, Acoba, and Duffy, JJ.

OPINION: ORDER DENYING APPLICATION FOR WRIT OF CERTIORARI

Appendix A

Petitioner/Respondent-Appellant's application for writ of certiorari filed on June 1, 2004, is hereby denied.

DATED: Honolulu, Hawai'i, June 10, 2004.

NOT FOR PUBLICATION

NO. 24806

IN THE INTERMEDIATE COURT OF APPEALS

OF THE STATE OF HAWAI`I

FIRST INSURANCE COMPANY OF HAWAII, LTD.,
Complainant-Appellee,

vs.

EMERSON M. F. JOU, M.D., and EMERSON M. F. JOU, dba COMPREHENSIVE CLINIC OF REHABILITATION MEDICINE,

Respondents-Appellants,

And

SPECIAL COMPENSATION FUND,

Appellee

Appendix B

APPEAL FROM THE LABOR AND INDUSTRIAL RELATIONS APPEALS BOARD
(Case No. MISC 90-001)
(C-9001) (2-87-11296)

SUMMARY DISPOSITION ORDER
(By: Lim, Acting C.J., Foley and Nakamura, JJ.)

Respondent-Appellant Emerson M.F. Jou, M.D., dba Comprehensive Clinic of Rehabilitation Medicine (Dr. Jou or Appellant), appeals the December 17, 2001 decision and order of the Labor and Industrial Relations Appeals Board (the Appellate Board). The Appellate Board's decision and order affirmed the November 21, 1990 decision and the October 30, 1991 supplemental decision of the Director of Labor and Industrial Relations (the Director), both in favor of Complainant-Appellee First Insurance Company of Hawaii, Ltd. (FICOH), and both of which Dr. Jou had appealed to the Appellate Board.

Upon a painstaking review of the record and the briefs submitted by the parties, and giving sedulous consideration to the arguments advanced and the issues raised by the parties, we resolve Dr. Jou's points of error on appeal as follows:

1. Dr. Jou first avers that the advisory panel, convened by the Director for assistance pursuant to Hawaii Revised Statutes (HRS) § 386-27(d) (1993)[1] and Hawaii Administrative Rules (HAR) §§ 12-13-20, -21 & -22 (January 1, 1990 - December 31, 1992), violated his constitutional rights. Specifically, Dr. Jou contends, "At least one decisionmaker relied on by the agency (Dr. Calvin [C.M.] Kam [(Dr. Kam)]), was personally and financially

interested in his decision against Appellant, in violation of Article 1, Section 5 of the Constitution of the State of Hawaii, and the Fifth and Fourteenth Amendments to The United States Constitution." Opening Brief at 2 (citation to appendix omitted). This argument is unavailing. Dr. Jou's appeal to the Appellate Board was a *de novo* proceeding, HRS § 386-27(d) ("Any person aggrieved by a decision of the director may appeal the decision under section 386-87."); HRS § 386-87(b) (1993) ("The appellate board shall hold a full hearing de novo on the appeal."), and nothing in the record indicates the Appellate Board relied upon the recommendations the advisory panel made to the Director. Indeed, the record affirmatively shows that the Appellate Board could not have relied upon the panel's recommendations, because the propriety *vel non* of the Director's convening of the advisory panel -- specifically, FICOH's choice of Dr. Kam -- was an issue to be decided and in fact decided on appeal by the Appellate Board at the behest of Dr. Jou. Furthermore, we are somewhat nonplused by Dr. Jou's animadversions upon alleged bias on the part of Dr. Kam, because an advisory panel member selected by a party pursuant to HRS § 386-27(d) can be expected to be attuned to that party. Cf. Daiichi Hawaii Real Estate Corp. v. Lichter, 103 Hawaii 325, 343, 82 P.3d 411, 429 (2003) ("Arising out of the repeated use of the tripartite arbitral board, there has grown a common acceptance of the fact that the party-designated arbitrators are not and cannot be 'neutral,' at least in the sense that the third arbitrator or a judge is." (Citation and internal quotation marks omitted.)). Dr. Jou well realized this fact of life all along, as is evidenced by his objection to the selection of Dr. Kam, raised before the panel convened, as "the other side's hired gun[.]" We note in this respect that Dr. Jou selected his own "hired gun" to serve on the advisory panel. In any event, Dr. Jou does not point out,

and nothing in the record indicates, that Dr. Kam -- though certainly strongly opinionated against Dr. Jou's diagnoses and treatments -- participated in the advisory panel unfairly, dishonestly or in bad faith. Cf. id. at 344, 82 P.3d at 430 ("The fact that party selected arbitrators are not expected to be 'neutral,' however, does not mean that such arbitrators are excused from their ethical duties and the obligation to participate in the arbitration process in a fair, honest, and good-faith manner." (Brackets, citation and internal quotation marks omitted.)). As for Dr. Jou's allegation that Dr. Kam was paid more than the other panel members, the record confirms that Dr. Kam was paid by the special compensation fund the same amount ($200) as the other panel members, pursuant to HRS § 386-27(d) and HAR § 12-13-22. Finally, we observe that all of the cases relied upon by Dr. Jou in this connection dealt with adjudicators. See, e.g., In re Water Use Permit Applications, 94 Hawai`i 97, 122, 9 P.3d 409, 434 (2000). In our case, the advisory panel was just that, advisory. This final point also disposes of Dr. Jou's cursory argument that the advisory panel scheme of HRS § 386-27(d) "impermissibly delegated governmental power to private individuals[.]" Opening Brief at 26 (citation to the appendix omitted)).

2. Dr. Jou next asserts that the workers' compensation medical fee schedule (MFS), by restricting compensation for physical therapy to services provided by "duly registered physical therapist[s,]" HAR § 12-13-1 (January 1, 1987 - December 31, 1989) (definition of "therapist"), "is inconsistent with the licensing statutes for physicians in this State." Opening brief at 27 (citation omitted). Essentially, Dr. Jou, a physiatrist, invokes a sort of medical hierarchy in arguing that a physiatrist may bill under the MFS for any services, including physical therapy services, rendered within the physiatrist's field of expertise,

regardless of whether the physiatrist is licensed to provide the particular services. For support, Dr. Jou cites the licensing statutes for physicians and certain Medicare billing policies, all of which are, however, inapposite and unavailing. Besides, Dr. Jou admitted, and the Appellate Board found, that he did not provide the physical therapy services he billed for and, indeed, was elsewhere in his clinic when the services were being provided by unlicensed staff. Dr. Jou also contends the relevant provisions of the MFS work a taking of his property without due process of law, "in violation of the Fifth Amendment U.S. Constitution and Article 1, Section 5 of the Hawaii Constitution[.]" Opening Brief at 27 (capitalization modified). Dr. Jou makes no detectable argument in support of this assertion, and thus fails in his burden on appeal to prove the administrative provisions unconstitutional beyond a reasonable doubt, and to show the constitutional defect clearly, manifestly and unmistakably. Sifagaloa v. Bd. of Tr. of the Employees' Ret. Sys. of the State of Hawaii, 74 Haw. 181, 191, 840 P.2d 367, 371 (1992). This second point on appeal lacks merit.

3. Dr. Jou's final argument, in its entirety, is as follows: "Any alleged violation was to be calculated within the two year bar, pursuant to HRS § 386-27(d). As to those alleged violations there was no jurisdiction to include them in the calculations." Opening Brief at 32. We disagree. HRS § 386-27(d) provides in pertinent part that, "No sanction shall be imposed by the director under this section except upon submission of a written complaint which shall specifically allege that a violation of this section occurred within two years of the date of the complaint." In construing statutes, "our foremost obligation is to ascertain and give effect to the intention of the legislature, which is to be obtained primarily from the language contained in the statute itself."

Water Use, 94 Hawai`i at 144, 9 P.3d at 456 (citation and block quote format omitted). The written complaint in this case specifically alleged that more than a hundred violations of HRS § 386-27 occurred within two years of the date of the complaint.

Therefore,

IT IS HEREBY ORDERED that the December 17, 2001 decision and order of the Appellate Board is affirmed.

DATED: Honolulu, Hawaii, May 7, 2004.

On the briefs:

Stephen M. Shaw, for respondent-appellant.

Dennis E. W. O'Connor,
Kelvin H. Kaneshiro and
Jeffrey K. Hester (Reinwald, O'Connor & Playdon), for complainant-appellee.

1. Hawaii Revised Statutes (HRS) § 386-27 (1993) provides:

(a) All health care providers rendering health care and services under this chapter shall be qualified by the director and shall remain qualified by satisfying the requirements established in this section. The director shall qualify any person initially who has a license for the practice of:

(1) Medicine under chapter 453;

(2) Dentistry under chapter 448;

(3) Chiropractic under chapter 442;

(4) Osteopathy under chapter 460;

(5) Naturopathy under chapter 455;

(6) Optometry under chapter 459;

(7) Podiatry under chapter 463E; or

(8) Psychology under chapter 465.

(b) To remain a qualified provider under this chapter a health care provider shall:

(1) Comply with guidelines established by the director on the frequency of treatment and reasonable utilization of health care and services;

(2) Conform to limitations established by the director for charges on services under medical fee and other fee schedules;

(3) File timely reports required under section 386-96;

(4) Avoid unnecessary and unreasonable referrals of injured employees to other health care providers;

(5) Refrain from ordering unnecessary and unreasonable diagnostic tests and studies;

(6) Remain available as a treating health care provider to injured employees and as an advisor to the director in proceedings under this section; and

(7) Comply with all requirements established under this chapter and by rules and decisions adopted and issued by the director pursuant to this chapter.

(c) Any health care provider who fails to comply with subsections (a) and (b) may be subject to such sanctions deemed just and proper by the director which may include:

(1) Disallowance of fees for services rendered to an injured employee;

(2) Forfeiture of payments for services rendered to an injured employee under this chapter;

(3) Fines of not more than $1,000 for each violation;

(4) Suspension as a qualified provider; and

(5) Disqualification as a provider of services under this chapter.

(d) No sanction shall be imposed by the director under this section except upon submission of a written complaint which shall specifically allege that a violation of this section occurred within two years of the date of the complaint. A copy of the complaint shall be sent to the health care provider charged promptly upon receipt by the

director. The director may establish an advisory panel of health care providers consisting of three members, one selected by the complainant, another selected by the health care provider charged, and the third selected by the director who shall assist the director in any case arising under this section. Fees for services rendered by members of the advisory panel shall be paid for by the special compensation fund. No member of the advisory panel shall be liable in damages for libel, slander, or other defamation of character of any party for any action taken while acting within their capacities as members of the advisory panel.

The director shall issue, where a sanction is ordered under this section, a written decision of findings following a hearing held upon not less [than] twenty days written notice to the complainant and the health care provider charged. No violation shall be found unless the director determines that the violator acted in bad faith. Any person aggrieved by a decision of the director may appeal the decision under section 386-87.

(e) In any case arising under this section, the injured employee treated by the health care provider charged with a violation of this section shall not be a party to the proceeding and shall not appear unless called as a witness before the director or the appellate board. Charges for services rendered by the health care provider alleged to be in violation of this section shall be suspended pending action by the director and the appellate board in cases on appeal.

In any case in which fees for services rendered by a health care provider are disallowed by the director, the health care provider shall be ordered to forfeit payment.

FIRST INSURANCE COMPANY, OF HAWAII, LTD.,Complainant-Appellee, vs. EMERSON M.F. JOU, M.D., and EMERSON M.F. JOU, dbaCOMPREHENSIVE CLINIC OF REHABILITATION MEDICINE, Respondent-Appellant, andSPECIAL COMPENSATION FUND, Appellee

CASE NO. AB MISC 90-001; C-9001; 2-87-11296

Hawaii Labor and Industrial Relations Appeals Board

2001 HI Wrk. Comp. LEXIS 150

December 17, 2001

COUNSEL:
Dennis E.W. O'Connor, Esq., Kelvin H. Kaneshiro, Esq., for Complainant-Appellee; Stephen M. Shaw, Esq., for Respondent-Appellant; Leo B. Young, Esq., for the Special Compensation Fund-Appellee

JUDGES: RANDALL Y. IWASE, Chairman; CAROL K. YAMAMOTO, Member; VICENTE F. AQUINO, Member, concurring

OPINION:
[*1] [*1]

DECISION AND ORDER

This workers' compensation case is before the Board on appeals by EMERSON M.F. JOU, M.D. and EMERSON M.F. JOU, dba COMPREHENSIVE CLINIC OF REHABILITATION MEDICINE ("Dr. Jou ") from the

Appendix C

decisions of the Director dated November 21, 1990 and October 30, 1991.

Procedural History

On November 21, 1990, the Director issued a decision in which he determined that Dr. Jou acted in "bad faith" and violated Hawaii Revised Statutes ("HRS") § 386-27. The Director ordered Dr. Jou to forfeit or reimburse FIRST INSURANCE COMPANY OF HAWAII, LTD. ("First Insurance") for payments made to Dr. Jou for services that were not allowed or authorized by the Hawaii Workers' Compensation Administrative Rules and Medical Fee Schedule ("MFS"). The Director further ordered Dr. Jou not to charge the disallowed fees to Pao Watanabe ("Claimant") and to pay a fine of $7,000.00, payable to the SPECIAL COMPENSATION FUND ("SCF") for violating the workers' compensation statute, the related administrative rules, and the MFS.

Dr. Jou appealed the November 21, 1990 decision to the Board.

By letter dated November 29, 1990, First Insurance advised the Director that he neglected to rule on its[*2] request[*2] for assessment of partial attorney fees and costs against Dr. Jou for prosecuting the HRS § 386-27 complaint at the Disability Compensation Division.

By letter dated December 7, 1990, the Director denied First Insurance's request for partial attorney's fees and costs.

By Order of Temporary Remand dated April 2, 1991, the Board remanded the case back to the Director to determine, among other things, the correct amount that Dr. Jou

should have billed for his services, and the amount that Dr. Jou should reimburse to First Insurance for unauthorized or disallowed billings.

On October 30, 1991, the Director issued a supplemental decision that allowed Dr. Jou fees of $2,241.93 for services provided to Claimant for the period between August 31, 1987 and July 27, 1990, and ordered him to reimburse First Insurance the amount of $16,950.61. -

Issues on Appeal

The issues for determination on appeal are:

1. Whether the Director properly concluded that Dr. Jou had violated the requirements of HRS § 386-27, and the related administrative rules and MFS so as to order Dr. Jou to reimburse First Insurance for billings for medical care provided to Claimant relative to her injury [*3] of March 11, 1987, [*3] not authorized or computed in accordance with the administrative rules; n1

n1 This case involves the interpretation and application of Title 12 Chapter 13 of the administrative rules, which includes the MFS, and HRS § 386-27 that were in effect during the period Dr. Jou treated Claimant. As indicated in our findings below, Dr. Jou treated Claimant between August of 1987 and July of 1990.

2. Whether the Director properly determined that disallowed fees are not chargeable to Claimant, pursuant to § 12-13-13(a) (14) of the administrative rules and MFS;

3. Whether the Director properly convened the medical panel;

4. Whether First Insurance is entitled to attorney's fees and costs incurred at the Disability Compensation Division to be paid by Dr. Jou; and

5. Whether the reimbursement ordered by the Director in his supplemental decision of October 30, 1991, was properly calculated; if not, what is the reimbursement that should be allowed for unauthorized or disallowed billings, if any.

For the reasons stated below, we affirm the Director on all issues.

FINDINGS OF FACT

1. Between August 31, 1987 and July 27, 1990, Dr. Jou treated Claimant for a work injury [*4] by providing various modalities[*4] of physical therapy and conservative treatment.

2. Dr. Jou is a medical doctor whose practice is in the field of physiatry.

3. For the period between August 31, 1987 and July 27, 1990, Dr. Jou employed a staff of licensed massage therapists and physical therapy assistants who were not registered physical therapists. Dr. Jou did not have any licensed or registered physical therapists on his staff during the period in question.

4. Some of the members of Dr. Jou's staff of massage therapists or physical therapy assistants provided

treatment or physical therapy to Claimant during the period in question.

5. On March 5, 1990, First Insurance filed with the Director a Complaint pursuant to HRS § 386-27, alleging, among other things, that Dr. Jou violated HRS § 386-26 and -27, Administrative Rules § 12-13-12(b), § 12-13-13(a), § 12-13-36, § 12-13-38, § 12-13-40, § 12-13-80, and § 12-13-91, and § 12-13-95 of the MFS during the treatment of Claimant. Some of the allegations contained in the Complaint included bad faith submission of misleading billings and failure to file the proper reports as required by the administrative rules and MFS.

6. Pursuant to[*5] HRS § 386-27, the Director exercised [*5] its option to convene a three-member advisory panel of health care providers to assist him in evaluating the allegations contained in First Insurance's Complaint.

As provided for by statute, First Insurance exercised its choice of physician to serve on the panel by selecting Dr. Calvin Kam. Dr. Jou selected Dr. Bernard Portner as his choice to serve on the panel. The Director selected Dr. David Kimura as his choice to serve as Chairperson of the panel.

7. Claimant objected to First Insurance's selection of Dr. Kam as a panelist. According to Claimant, Dr. Kam was a biased panelist, because he was previously retained by First Insurance in Claimant's workers' compensation case to evaluate the propriety of Dr. Jou's treatment, and had rendered an opinion adverse to Dr. Jou in this regard.

8. On or about July 3, 1990, the advisory panel was convened by the Director. Dr. Jou appeared before the

panel to address the allegations contained in the Complaint and to present his position.

9. On July 20, 1990, Dr. Portner and Dr. Kimura submitted a joint report containing their opinions and recommendations. Dr. Portner and Dr. Kimura determined that[*6] based on their review of the medical records [*6] and Dr. Jou's testimony before the panel, Dr. Jou may have violated administrative rules § 12-13-13(10)(d) through his persistent use of treatment of non-specific measures. Dr. Portner and Dr. Kimura recommended that Dr. Jou be reprimanded.

Dr. Kam did not agree with all of the opinions set forth by Dr. Portner and Dr. Kimura, and submitted his own "minority opinion." It was Dr. Kam's opinion that Dr. Jou violated more than just § 12-13-13(10)(d) by not referring Claimant for psychiatric care, by not obtaining medical records from medical providers who had treated Claimant in the past, by prolonging passive physical therapy when it was no longer necessary, and by not following reporting requirements. Dr. Kam, however, concurred with the majority's recommendation of a reprimand.

The panel's decision did not address the allegations relating to Dr. Jou's billing or reporting procedures, because those issues did not require medical expertise.

10. On August 21, 1990, First Insurance filed an Amended Complaint against Dr. Jou, pursuant to HRS § 386-27, to include additional allegations of wrongdoing that included, among other things, [*7] bad faith by Dr. Jou when he allowed at least two unlicensed[*7] physical therapists to provide physical therapy to Claimant without direct supervision by Dr. Jou, and billed First Insurance for

those services as though they were provided by licensed physical therapists.

11. By decision dated November 21, 1990, the Director determined that Dr. Jou committed bad faith and violated HRS § 386-27 and related administrative rules, including § 12-13-13(a)(3), (4), and (8). In his decision, the Director found that Dr. Jou provided treatments that were unnecessary and inappropriate, that he allowed unlicensed individuals to provide physical therapy treatments to Claimant without proper supervision, that Dr. Jou improperly billed these services under codes reserved for registered physical therapists, that he failed to prepare or submit appropriate reports to indicate the nature and efficacy of the treatment he provided to Claimant, and that he submitted inaccurate and misleading bills for payment. The Director disallowed billings for physical therapy treatments provided by unlicensed physical therapists, ordered Dr. Jou to forfeit or reimburse First Insurance for payments on billings that[*8] were not authorized by the administrative rules or the MFS, and, [*8] in accordance with § 12-13-13(a)(14) of the administrative rules, prohibited Dr. Jou from charging the disallowed fees directly to Claimant. The Director fined Dr. Jou $7,000.00 payable to the SCF.

12. Dr. Jou appealed the Director's November 21, 1990 decision to the Board.

13. By Order dated April 2, 1991, the Board temporarily remanded the case back to the Director to determine the correct amount that Dr. Jou should have billed to First Insurance and the amount that Dr. Jou must reimburse to First Insurance for payments made for billings that were not allowed by law.

14. While the case was on remand, First Insurance hired AccuMed, a medical billing service company, to audit Dr. Jou's billings in Claimant's case.

15. Records show that between August 31, 1987 and July 27, 1990, Dr. Jou billed First Insurance a total of $23,503.14 for treatments provided to Claimant for her work injury. First Insurance paid Dr. Jou $19,192.54 for treatments provided to Claimant for her work injury.

16. Based on its review of the billing records, AccuMed determined that Dr. Jou was entitled only to $5,698.98 for services provided[*9] to Claimant. First Insurance submitted the AccuMed audit to the Director[*9] as evidence, and requested a reimbursement of $13,493.56 ($19,192.54 - $5,698.98), based on the AccuMed calculations.

17. At an October 4, 1991 hearing before the Director, Dr. Jou, who was represented by counsel, sought to exclude the AccuMed calculations from evidence. The Director did not exclude the AccuMed report, but instead, granted Dr. Jou's request for time to respond to the AccuMed report, and allowed Dr. Jou until October 15, 1991, to submit a written response to rebut the AccuMed report.

Dr. Jou, however, did not submit any written response or rebuttal to the AccuMed report by October 15, 1991.

18. By supplemental decision dated October 30, 1991, the Director determined that Dr. Jou was entitled to fees in the amount of $2,241.93 for services provided to Claimant from August 31, 1987 to July 27, 1990. The Director ordered Dr. Jou to reimburse First Insurance the sum of $16,950.61 ($19,192.54 - $2,241.93). The Director reiterated that only

physical therapy treatments performed by licensed or registered physical therapists would be allowed and that First Insurance shall not be liable for[*10] any treatments not covered by approved treatment plans.

19. Dr. Jou, through [*10] his attorney, appealed the October 30, 1991 supplemental decision. According to Dr. Jou, the heart of the dispute on this appeal is whether he, as a physiatrist and medical doctor, should be allowed to submit bills for services provided by licensed massage therapists or physical therapy assistants pursuant to codes reserved for registered physical therapists.

Bad Faith

20. During the period he treated Claimant, Dr. Jou was aware that, pursuant to the administrative rules and the MFS, the billing codes 97418 and 97419 were reserved for physical therapy treatment provided by registered physical therapists. Dr. Jou knew of this since 1986.

21. Dr. Jou admitted in his deposition of May 22, 2001, and at trial that he did not employ any registered physical therapists on his staff during the period he treated Claimant. Dr. Jou also did not employ any licensed or unlicensed physician assistants on his staff during the period Claimant was under his care.

22. Massage therapists and physical therapy assistants employed by Dr. Jou provided physical therapy treatments to Claimant during the period she treated [*11]with him.

23. Dr. Jou billed First Insurance for treatments provided by his massage [*11]therapists and physical

therapy assistants as physical therapy performed by registered or licensed physical therapists under MFS billing codes 97418 and 97419.

24. Dr. Jou knowingly used the billing codes that were reserved for registered physical therapists even though no registered physical therapists provided treatment to Claimant.

25. Dr. Jou believed that the MFS that was in effect when he treated Claimant was "wrong" when it only allowed registered physical therapists to receive full payment for physical therapy services. According to Dr. Jou, prior to 1986, the law did not restrict codes 97418 and 97419 to registered physical therapists. In or around 1986, Dr. Jou discovered that the law had changed.

26. Dr. Jou did not agree with the MFS that allowed for full payment of physical therapy services provided by a registered physical therapist, and less than full payment if he, who is a physiatrist, but not a registered physical therapist, or any other nonregistered physical therapist, performs physical therapy on Claimant. According to Dr. Jou, under his interpretation of the MFS and § [*12] 12-13-45 of the administrative rules as it applies to physician assistants, he would only receive[*12] 60% of what a registered physical therapist would receive for the same service, even though, in his view, he was more educated than a physical therapist, and more qualified to provide physical therapy. n2 Dr. Jou believed that it was wrong to compensate a physical therapist more than a physician.

n2 Under § 12-13-45 of the administrative rules, a physician may bill for services performed by a licensed

physician assistant under his direct supervision at a reduced rate of 60% of the allowable charges. Section 12-13-45 is not applicable in this case, because Dr. Jou did not employ any licensed physician assistants and because physical therapy was not performed by any licensed physician assistants under his direct supervision.

27. Notwithstanding Dr. Jou's arguments, there is no evidence that Dr. Jou ever personally provided physical therapy treatment to Claimant in this case. Physical therapy, in this case, had always been provided by licensed massage therapists and physical therapy assistants employed by Dr. Jou. Dr. Jou was in the building seeing other patients at the time physical[*13] therapy was being provided to Claimant by his staff of licensed massage therapists or physical therapy[*13] assistants, but he was not in the room where the treatments were taking place or otherwise directly supervising the provision of treatment by his staff.

28. Dr. Jou admitted that he never advised First Insurance that the physical therapy that he was billing for in Claimant's case was not performed by registered physical therapists. Dr. Jou stated that the subject never came up and he did not volunteer the information to First Insurance.

29. At some point in his testimony at trial, Dr. Jou indicated that he was confused by the MFS. Yet, at the same time, Dr. Jou stated that he disagreed with the MFS as it related to charges under the codes for registered physical therapists.

Based on Dr. Jou's testimony at trial, including his awareness and understanding of the changes in the MFS before and after 1986, we find that Dr. Jou was not confused about the law at the time he was treating Claimant and that he knew that what he was doing with respect to billing First Insurance for treatments that were not being performed by registered physical therapists was contrary to the law. We[*14] further find that Dr. Jou's bills misled First Insurance into believing that the physical therapy that it was [*14] paying for was performed by licensed physical therapists.

30. Based on the foregoing, we find that, with respect to the billing issue, Dr. Jou violated § 12-13-92 of the MFS by using improper billing codes reserved only for registered physical therapists and § 12-13-13(a)(8) by submitting misleading bills to First Insurance.

31. We further find that by billing First Insurance for physical therapy services under codes reserved for registered physical therapists even though he knew that the work he was billing for was not performed by registered physical therapists, Dr. Jou acted dishonestly and fraudulently.

32. Having found that Dr. Jou acted dishonestly and fraudulently in his billings, we further find that Dr. Jou's actions constituted bad faith for purposes of HRS § 386-27, § 12-13-1, and § 12-13-14.

Calculation of Amount of Reimbursements

33. First Insurance's Exhibit 6 shows the Director's work product in arriving at the sums specified in the October 30, 1991 supplemental decision. Based on our review of the

record, it appears that the Director reviewed all[*15] of the bills submitted by Dr. Jou to First Insurance, and disallowed all billings that were made under codes 97418 and[*15] 97419. After that, the Director reviewed all of the treatment plans that were submitted by Dr. Jou and disallowed all treatments that were not covered by any approved treatment plans.

After deducting the disallowed billings, the Director determined that Dr. Jou was entitled to payments of $2,241.93. Since First Insurance had paid Dr. Jou $19,192.54, the Director ordered Dr. Jou to reimburse First Insurance the sum of $16,950.61.

34. Dr. Jou objected to the Director's calculations, alleging that it was improperly based on the AccuMed report. Dr. Jou's Exhibit A, which was submitted on appeal, shows his calculations.

The first column of Exhibit A reflects Dr. Jou's billings according to his interpretation of the MFS. Under Dr. Jou's interpretation, he should be allowed to use codes 97418 and 97419 even though no registered physical therapists provided physical therapy services to Claimant.

The second column of Exhibit A reflects Dr. Jou's billings according to his interpretation of the Director's November 21, 1990 decision. Under this interpretation, Dr. [*16] Jou amended his codes from 97418 and 97419 to other codes that would allow him to receive reduced payment for the same services. [*16]

The third column of Exhibit A reflects Dr. Jou's billings according to the AccuMed report.

35. Dr. Jou's Exhibit A did not specifically address the Director's calculations that formed the bases for the October 30, 1991 supplemental decision. According to Dr. Jou, he was unaware of the Director's October 30, 1991 supplemental decision until 1999, even though he was represented by counsel when the supplemental decision was issued. It was Dr. Jou's understanding that the Director's October 30, 1991 supplemental decision was based on the improper AccuMed audit.

36. Contrary to Dr. Jou's assertions, the Director's calculations in the October 30, 1991 supplemental decision were not based on the AccuMed report submitted by First Insurance. The Director's calculation of the amount of reimbursement differed from the AccuMed calculation.

37. Based on our review of the record, we find that the Director properly disallowed billings for treatments that were performed by individuals who were not licensed physical therapists.

38. With respect to the Director's[*17] disallowance of billings for office visits or treatments not covered by an approved treatment plan, we reviewed Exhibit 6 and the Director's[*17] calculations and find that Dr. Jou billed First Insurance for certain treatments that were in excess of the guidelines set by the administrative rules, and not covered by an approved treatment plan, in violation of § 12-13-38 of the administrative rules. Accordingly, we find that the treatments identified by the Director were not authorized treatment under the administrative rules.

39. Dr. Jou testified at trial that he believed that all of his treatments were performed pursuant to approved treatment plans. Dr. Jou provided no explanation as to

why certain treatments, as identified in First Insurance's Exhibit 6, were not covered by an approved treatment plan. Dr. Jou presented no documentary evidence to rebut the Director's findings or Exhibit 6.

40. Having reviewed Exhibit 6 and the Director's calculations, we find that the Director's calculation of the amount of reimbursement to be paid by Dr. Jou was proper and supported by the record.

CONCLUSIONS OF LAW

1. Under HRS § 386-27 and § 12-13-14 of the administrative rules, the Director, **[*18]** after a finding of bad faith, may sanction a medical provider with, among other things, disallowance of fees for services rendered to an injured employee, **[*18]** or forfeiture of payments for services rendered to an injured employee.

For purposes of § 386-27 and § 12-13-14, bad faith, according to § 12-13-1 of the administrative rules, requires a finding of a fraudulent, malicious, dishonest, or frivolous act or omission. Mere carelessness, bad judgment, or ordinary negligence, in and of themselves, do not constitute bad faith.

In this case, we found that Dr. Jou acted dishonestly and fraudulently in his billings for physical therapy, and that his actions constituted bad faith.

Based on our findings, we conclude that the Director properly determined that Dr. Jou violated the requirements of HRS § 386-27, and the related administrative rules and MFS, and properly ordered reimbursement to First Insurance for billings for services

that were not authorized or computed in accordance with the rules or the MFS.

2. Section 12-13-13(a)(14) of the administrative rules prohibits a health care provider from charging fees to an injured employee which have been disallowed or forfeited. Accordingly, [*19] we conclude that the Director properly determined that disallowed fees are not chargeable to Claimant.

3. Pursuant to HRS § 386-27(d) and § 12-13-20, the Director[*19] has the discretion to convene an advisory panel if he determines that one is necessary. Our review of the record shows that the panel was convened in accordance with the statute and related administrative rules. Claimant has presented no evidence to show that the panel was improperly convened. Claimant's objection to First Insurance's choice of panelist is not a legal ground to bar the Director from convening an advisory panel.

4. First Insurance did not present any evidence or argument on appeal as to why the Director erred in denying its request for attorney's fees and costs incurred at the DCD level to be paid by Dr. Jou. Because First Insurance failed to sustain its burden to show that the Director erred on this issue, we conclude that First Insurance is not entitled to attorney's fees and costs sustained at the DCD.

5. Based on the foregoing findings and Dr. Jou's failure to rebut successfully the Director's calculations, we conclude that the amount of reimbursement ordered by the Director in his supplemental[*20] decision of October 30, 1991, was properly calculated.

ORDER

The decisions of the Director, dated November 21, 1990 and October 30, 1991, are affirmed, in accordance with[*20] the foregoing.

Dated: Honolulu, Hawaii, DEC 17 2001.

CONCURBY: VICENTE F. AQUINO, Member

CONCUR:

I concur:

The fundamental issue in this case is whether Dr. Emerson M.F. Jou ("Dr. Jou ") acted in "bad faith", thereby violating Section 386-27, HRS, when he billed First Insurance Company of Hawaii, Ltd., ("First Insurance") for services of licensed physical therapists ("PT") performed by unlicensed PT.

During the period he treated Claimant, Dr. Jou had no employed licensed PT and knew that Claimant was actually being treated by his unlicensed PT yet he continued to bill First Insurance for services reserved for licensed PT. The evidence clearly indicates that this sole motive in doing so was to charge First Insurance higher than what he could have charged as a physician. The fact that the subject never came up is inconsequential. Here, his modus operandi was obviously designed to mislead or deceive First Insurance. This is not a case of mere bad judgment or negligence, but rather a conscious doing of a wrong because of dishonest[*21] purpose, which constitutes "bad faith" under Section 386-27, HRS.

I would affirm the Director's decisions dated November 21, 1990 and October 30, 1991.

SUPREME COURT RULE 14(F) TEXT OF PROVISIONS INVOLVED (Emphasis Added)

A. Medicare B. News, August 14, 1998

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. . .

"Services may be billed under one of three different practitioner benefits: (1) by physicians as their own professional services or as services of their employees furnished 'incident to' their professional services (2) by physical therapists in independent practice or (3) by occupational therapists in independent practice. The term 'provider' in this policy includes any of these three." [Emphasis added.]

. . .

. . .

"This term means services that are:

1. furnished as an integral, although incidental, part of a physician's personal professional services;
2. performed under the physician's direct personal supervision;
3. performed by therapists or other auxiliary personnel who are employees of the physician; and
4. furnished during a course of treatment where the physician performs an initial direct, personal, professional service and performs subsequent services at a frequency that reflects his/her continuing active participation in the management of the course of treatment." Id. [Emphasis added.]

. . .

This term [direct personal supervision] means that the provider must be physically present in the same office suite and immediately available to provide assistance and direction throughout the time the employee is performing services.

In a physician-directed clinic where responsibility is shared for supervision of medical services performed by employees of the clinic, the physician who orders a service is not necessarily the same physician who provides direct personal medical supervision while the service is performed (MCM 2050f.)."

B. Code Of Federal Regulations, 42 CFR 410.60

@410.60 Outpatient physical therapy services: Conditions.

(a) Basic rules. Medicare Part B pays for outpatient physical therapy services if they meet the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(2) They are furnished under a written plan of treatment that meets the requirements of @410.60.

(3) They are furnished –

(i) By a provider as defined in @489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By or under the personal supervision of a physical therapist in private practice as described in paragraph (c) of this section.

(b) Out patient physical therapy services furnished to certain inpatients of a hospital or a CAH or SNF. Medicare Part B pays for outpatient physical therapy services furnished to an inpatient of a hospital, CAH, or SNF who requires them Medicare Part A.

(c) Special provisions for services furnished by physical therapists in private practice. (1) Basic qualifications. In order to qualify under Medicare as a supplier of outpatient physical therapy services, each individual physical therapist in private practice must meet the following requirements:

.....

.....

(iii) Bill Medicare only for services furnished in his or her private practice office space,or in the patient's home. A therapist's private practice office space refers to the location9s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location. When services are furnished in private practice office space, that space must be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. A patient's home does not include any institution that is a hospital, a CAH, or a SNF.

...

C. Excerpts From Hawaii's medical Fee Schedule

"PHYSICAL MEDICINE

The following values apply only when these services are under the continuous and direct supervision of a physician. Additional charges for office visits are allowed when specific additional services warrant such extra charges (e.g., major dressing, special examination). Only physical therapists licensed to practice in the State of Hawaii may provide physical therapy services."

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"97417 each additional 15 minutes . . . . . .

97418 Physical therapy treatment by registered physical therapist including combination of any of the above modalities and procedures, initial 15 minutes 1.0

97419 each additional 15 minutes .....1.0"

See Petitioner's application below for discretionary review in the Hawaii Supreme Court at 9 and Appendices 9-13, thereof.

D. Hawaii Statute Relating To State's Appointed Advisory Panel Charged With Subpoena Powers Complaint Review And "Recommending Agency Decisions"

[§386-27] Qualification and duties of health care providers. (a) All health care providers rendering health care and services under this chapter shall be qualified by

the director and shall remain qualified by satisfying the requirements established in this section. The director shall qualify any person initially who has a license for the practice of:

(1) Medicine under chapter 453;

. . . ...

. . . . . .

(b) To remain a qualified provider under this chapter a health care provider shall:
(1) Comply with guidelines established by the director on the frequency of treatment and reasonable utilization of health care and services;
(2) Conform to limitations established by the director for charges on services under medical fee and other fee schedules;
(3) File timely reports required under section 386-96;
(4) Avoid unnecessary and unreasonable referrals of injured employees to other health care providers;
(5) Refrain from ordering unnecessary and unreasonable diagnostic tests and studies;
(6) Remain available as a treating health care provider to injured employees and as an advisor to the director in proceedings under this section; and
(7) Comply with all requirements established under this chapter and by rules and decisions adopted and issued by the director pursuant to this chapter.

(c) Any health care provider who fails to comply with subsections (a) and (b) may be subject to such sanctions deemed just and proper by the director which may include:

(1) Disallowance of fees for services rendered to an injured employee;
(2) Forfeiture of payments for services rendered to an injured employee under this chapter;
(3) Fines of not more than $1,000 for each violation;
(4) Suspension as a qualified provider; and
(5) Disqualification as a provider of services under this chapter.

(d) No sanction shall be imposed by the director under this section except upon submission of a written complaint which shall specifically allege that a violation of this section occurred within two years of the date of the complaint. A copy of the complaint shall be sent to the health care provider charged promptly upon receipt by the director. The director may establish an advisory panel of health care providers consisting of three members, one selected by the complainant, another selected by the health care provider charged, and the third selected by the director who shall assist the director in any case arising under this section. Fees for services rendered by members of the advisory panel shall be paid for by the special compensation fund. No member of the advisory panel shall be liable in damages for libel, slander, or other defamation of character of any party for any action taken while acting within their capacities as members of the advisory panel.

The director shall issue, where a sanction is ordered under this section, a written decision of findings following a hearing held upon not less than twenty days written notice to the complainant and the health care provider charged. No violation shall be found unless the director determines that the violator acted in bad faith. Any person

aggrieved by a decision of the director may appeal the decision under section 386-87.

(e) In any case arising under this section, the injured employee treated by the health care provider charged with a violation of this section shall not be a party to the proceedings and shall not appear unless called as a witness before the director or the appellate board. Charges for services rendered by the health care provider alleged to be in violation of this section shall be suspended pending action by the director and the appellate board in cases on appeal.

In any case in which fees for services rendered by a health care provider are disallowed by the director, the health care provider shall be ordered to forfeit payment. [Emphasis added].

E. Hawaii Administrative Rules Relating To Advisory Panel

§12-13-1 Definitions. As used in this chapter:

"Advisory panel" means the advisory panel of health care providers appointed by the director pursuant to section 386-27, HRS.

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§12-13-20 Advisory panel of health care providers. (a) When the director determines an advisory panel is necessary, the director shall notify the complainant and the health care provider of concern. The complainant and the health care provider of concern shall submit the names of

their preferred advisory panelist and two alternates to the director.

(b) If any party fails to submit names within the time allowed by the director, the director may select on behalf of that party, a person to fill that party's panelist's position. The director shall then notify the advisory panel of the panelist's name, the date of review, and the facts of the case.

(c) If any panelist considers the nature of the case to be within the panelist's scope and field of expertise, and does not represent a conflict of interest, the panelist shall notify the director of the panelist's availability. If any panelist is unable to attend the review for any reason, the director shall notify the next alternate.

(d) The director shall select a health care provider in the relevant specialty area to represent the director on the advisory panel for the complaint reviewed. The health care provider shall be available to the department for consultation, or panel review, or both.

(e) The advisory panel shall be chaired by the health care provider appointed by the director and may meet with the director as deemed necessary to review the complaint. [Eff 11/29/85] (Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27) [Emphasis added].

§12-13-21 Advisory panel function. (a) The advisory panel shall have the right to request or subpoena through the director relevant information, such as x-rays and chart notes on each case. The health care provider against whom the complaint has been filed shall be notified of the health

care provider's right to appear before the advisory panel at a specified time and place for a review of the complaint.

(b) After the review, the advisory panel shall recommend to the director disposition of the case.

(c) Should the health care provider of concern fail or decline to appear, the advisory panel shall recommend to the director appropriate action based on the available evidence.

(d) After receipt of the recommendation of the advisory panel, the director shall hold a hearing pursuant to section 386-86, HRS. [Eff 11/29/85] (Auth: HRS §§386-27, 386-72) (Imp: HRS §§386-27, 386-71, 371-6) [Emphasis added].

§12-13-22 Advisory panel fees. Each advisory panelist shall be paid from the special compensation fund at a rate of $200 for each complaint reviewed. [Eff 11/29/85] Auth: HRS §§386-27, 386-72) (Imp: HRS §386-27)

. . .

§12-13-31 Who may provide services. (a) All health care providers deemed qualified by the director may provide services to an injured employee. Treatment shall fall within the scope of the health care provider's license to practice.

. . .

F. Hawaii Statutes Defining The Scope Of A Physician's Practice, And The Practices OF Those He May Employ

In Hawaii, the practice of medicine is defined by HRS §453-1 as follows:

> "For the purposes of this chapter the practice of medicine includes the use of drugs and medicines, water, electricity, hypnotism, or any means or method, or any agent, either tangible or intangible, for the treatment of disease in the human subject; provided that when a duly licensed physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person's attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person." Emphasis added.

Also, in Hawaii, physical therapy is defined by HRS §461J-1 as follows:

"'Physical therapist' means a person who is licensed to practice physical therapy in this State.

'Physical therapy' or 'physical therapy services' means the examination, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction, pain from injury, disease, and any other physical or mental condition as performed by a physical therapist appropriately licensed under this chapter. It includes but is not limited to: (1) Administration, evaluation, modification of treatment, and instruction involving the use of physical measures, activities, and devices, for preventive and therapeutic

purposes, provided that should the care or treatment given by a physical therapist contravene treatment diagnosed or prescribed by a medical doctor, osteopath, or as determined by the board, the physical therapist shall confer with the professional regarding the manner or course of treatment in conflict and take appropriate action in the best interest of the patient; and (2) The provision of consultative, educational, and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction, or pain". Emphasis Added.

'Practice of physical therapy' includes, but is not limited to, the use of the following: (1) Physical agents, such as heat, cold, water, air, sound, compression, light, electricity, and electromagnetic radiation; (2) Exercise with or without devices, joint mobilization, mechanical stimulation; biofeedback; postural drainage; traction; positioning, massage, splinting, training in locomotion, and other functional activities with or without assisting devices; and correction of posture, body mechanics, and gait; (3) Tests and measurements of: muscle strength, force, endurance, and tone; joint motion, mobility, and stability; reflexes and automatic reaction; movement skill and accuracy; sensation and perception; peripheral nerve integrity; locomotor skill, stability, and endurance; activities of daily living; cardiac, pulmonary, and vascular functions; the fit, function, and comfort of prosthetic, orthotic, and other assisting devices; posture and body mechanics; limb strength, circumference, and volume; thoracic excursion and breathing patterns; vital signs; nature and locus of pain and conditions under which pain varies; photosensitivity; and the home and work physical environments." Emphasis added.

The scope of license for Hawaii massage therapy is defined by HRS §452-1 as follows:

"'Massage', 'massage therapy', and 'Hawaiian massage' commonly known as lomilomi, means any method of treatment of the superficial soft parts of the body, consisting of rubbing, stroking, tapotement, pressing, shaking, or kneading with the hands, feet, elbow, or arms, and whether or not aided by any mechanical or electrical apparatus, appliances, or supplementary aids such as rubbing alcohol, liniments, antiseptics, oils, powder, creams, lotions, ointments, or other similar reparations commonly used in this practice. Any mechanical or electrical apparatus used as described in this chapter shall be approved by the United States Food and Drug Administration.

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'Massage therapist' means any person who engages in the occupation or practice of massage for compensation."